Welcome to Our Practice

Please fill out all items completely.

Medical Alert

Office use only

Date:____________________

Patient Information

Patient Name____
First Name Initial Last Name Preferred Name

Street Address______________________________ City________________ State________ Zip__________

Mailing Address______________________________ City________________ State________ Zip__________

Sex: ☐M ☐F Age________ Birthdate______________ Soc. Sec. #__________________ Email______________________

Home Phone______________________ Cell Phone______________________ Work Phone______________________

Occupation______________________ Employer______________________ How Long?______________________

Spouse Name______________________ Spouse Occupation______________________

Primary Care Physician's Name______________________ Phone Number__________________ Date of Last Exam______________

Emergency Contact Name______________________ Relationship to Patient______________ Phone______________

Whom may we thank for referring you to our office?______________________

Policy Holder/Responsible Party Information

Name______________________________________ Relationship to Patient______________________

Street Address______________________________ City________________ State________ Zip__________

Primary Dental Insurance Company________________ Group #__________ ID #______________ Effective Date__________

Insurance Company Address______________________________________ Phone #__________________

Insured's Employer______________________ Insured's Soc. Sec. #______________ Insured's DOB______________

Secondary Dental Insurance Company________________ Group #__________ ID #______________ Effective Date__________

Insurance Company Address______________________________________ Phone #__________________

Insured's Employer______________________ Insured's Soc. Sec. #______________ Insured's DOB______________

Initials_______ I understand that I am financially responsible for all charges for services performed. I request that all dental benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the provider of service. If insurance proceeds are insufficient to cover my obligations for services rendered, I am liable for the shortfall. I authorize provider of service to release all information necessary to secure payment of benefits.

Dental History

Previous Dentist Name______________________ Date of Last Dental Visit______________ Date of Last Cleaning______________

What is the reason of your visit today?______________________________________

Do you have any dental problems now? Yes No Please explain______________________________
Are you interested in Whiter/Brighter teeth? Yes No
Do your gums bleed or hurt? Yes No
Do you have bad breath? Yes No
Do you clench or grind your teeth? Yes No
Do you ever have pain in jaw joints? Yes No
Are you sensitive to hot, cold, or sweets? Yes No
Have you ever received periodontal (Gum) therapy? Yes No
Do you take a fluoride supplement? Yes No
Have you ever had an upsetting dental visit? Yes No If Yes, Please explain______________________
How often do you brush your teeth?______________ How often do you floss?______________
Are you currently under the care of a dental specialist (Orthodontist, Periodontist, etc)? Yes No If Yes, Who?______________
Is there anything about your teeth or smile that you would like to change? Please explain.

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Is there anything else about having dental treatment that you would like us to know? Please explain.

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What kind of toothbrush do you use? ☐ Manual ☐ Electric

Health History Questionaire

Please answer the following questions

Question	Yes	No	
Is your general health good?	Yes	No	
Are you under the care of a physician?	Yes	No	If Yes, Please explain_______________________
Do you use tobacco?	Yes	No	If Yes, Please explain_______________________
Have you ever been hospitilized or had a major operation?	Yes	No	If Yes, Please explain_______________________
Have you ever had a serious head or neck injury?	Yes	No	If Yes, Please explain_______________________
Do you use controlled substances?	Yes	No	If Yes, Please explain_______________________
Have you ever responded adversely to medical/dental treatment?	Yes	No	If Yes, Please explain_______________________
Women: Are you pregnant or nursing?	Yes	No	If Yes, Please explain_______________________

Do you currently have or have you ever had any of the following conditions? Please explain below.

#	Condition	Yes	No	#	Condition	Yes	No	#	Condition	Yes	No
1	Heart Trouble/Disease	Yes	No	18	Problems with Immune System	Yes	No	35	Diabetes Type ______	Yes	No
2	Heart Attack/Failure	Yes	No	19	Lung Disease/Breathing Problem	Yes	No	36	Hypoglycemia	Yes	No
3	High Blood Pressure	Yes	No	20	Asthma	Yes	No	37	Kidney Problems	Yes	No
4	Low Blood Pressure	Yes	No	21	Emphysema or COPD	Yes	No	38	Cancer	Yes	No
5	Angina or Chest Pains	Yes	No	22	Sleep Apnea	Yes	No	39	Tumors or Growths	Yes	No
6	Artificial Heart Valve	Yes	No	23	Tuberculosis	Yes	No	40	Radiation Treatments	Yes	No
7	Heart Pacemaker	Yes	No	24	Epilepsy or Seizures	Yes	No	41	Chemotherapy	Yes	No
8	Irregular Heartbeat	Yes	No	25	Aids/HIV	Yes	No	42	Leukemia	Yes	No
9	Heart Murmur or MVP	Yes	No	26	Herpes	Yes	No	43	Jaundice or Liver Disease	Yes	No
10	Congenital Heart Disorder	Yes	No	27	Sexually Transmitted Disease	Yes	No	44	Hepatitis A, B, or C	Yes	No
11	Endocarditis	Yes	No	28	Psychiatric Care	Yes	No	45	Arthritis	Yes	No
12	Blood Disease	Yes	No	29	Drug Addiction	Yes	No	46	Artificial Joint	Yes	No
13	Anemia	Yes	No	30	Fainting Spells/Dizziness	Yes	No	47	Osteoporosis	Yes	No
14	Bleed or Bruise Easily	Yes	No	31	Glaucoma	Yes	No	48	Pins, Rods, Stints, or Shunts	Yes	No
15	Thyroid Problem	Yes	No	32	Stroke	Yes	No	49	Stomach/Intestinal Disease	Yes	No
16	Hives or Rash	Yes	No	33	Tonsillitis	Yes	No	50	Stomach Ulcers	Yes	No
17	Anaphylaxis	Yes	No	34	Sinus Problems	Yes	No	51	Acid Reflux/GERD	Yes	No

Please explain any Yes answers from above

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Please list any major illness not listed above

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Are you allergic or do you react adversely to any of the following?

Aspirin	Yes	No	Penicillin	Yes	No	Metal	Yes	No	Sedatives	Yes	No
Acrylic	Yes	No	Other Antibiotic_______________	Yes	No	Codeine	Yes	No	Latex	Yes	No
Sulfa Drugs	Yes	No	Local Anestheitcs	Yes	No	Tetracycline	Yes	No	Milk Protein	Yes	No

Other:____________________________

Medications

Please indicate any medications and/or supplements you have taken in the past 12 months

Antibiotics	Yes	No	Heart Medications	Yes	No
Aspirin (daily)	Yes	No	Nitroglycerine	Yes	No
Insulin or diabetes medication	Yes	No	Anticoagulants (e.g. Coumadin, Blood Thinners)	Yes	No
Herbal Supplements	Yes	No	Contraceptives/Birth Control Pills	Yes	No
Blood Pressure Medicine	Yes	No	Bisphosphonates (e.g. Fosamax, Boniva, Actonel, Zometa, etc.)	Yes	No

Please list all medications/supplements you are currently taking:

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I hereby certify that I have read and understand the foregoing and have filled out this Patient Information Sheet and Health History Questionaire completely. I have advised you of all medical problems of which I am aware. I will notify the dental health provider of any change in my health or medication at each visit. I understand that my failure to provide information on previous adverse reactions may cause unforseen negative reactions. I release Adam J Barr, DDS, PA of all liability regarding undisclosed medical history information. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction.

I hereby authorize Dr. Adam Barr, or his designee(s) to render dental care to me. I consent to any care which encompasses diagnostic or dental treatment which my dentist or his assistant/hygienist may deem necessary for my health and well-being.

Patient or Guardian's Signature_______________________________ Date_______________

Dentist's Signature_______________________________ Date_______________